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House Engrossed Senate Bill

State of Arizona  
Senate  
Forty-sixth Legislature  
Second Regular Session  
2004

# SENATE BILL 1166

AN ACT

AMENDING TITLE 20, CHAPTER 13, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-2330; AMENDING SECTION 36-2901.03, ARIZONA REVISED STATUTES; REPEALING SECTION 36-2906.01, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2001, CHAPTER 58, SECTION 19; AMENDING SECTION 36-2906.01, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2001, CHAPTER 344, SECTION 48; AMENDING SECTION 36-2912, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-2912.01 AND 36-2912.02; AMENDING SECTION 36-2913, ARIZONA REVISED STATUTES; MAKING AN APPROPRIATION; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Title 20, chapter 13, article 1, Arizona Revised Statutes,  
3 is amended by adding section 20-2330, to read:

4 20-2330. Participation in healthcare group

5 A. AN ACCOUNTABLE HEALTH PLAN MAY CONTRACT WITH THE ARIZONA HEALTH  
6 CARE COST CONTAINMENT SYSTEM ADMINISTRATION TO PROVIDE HEALTH CARE SERVICES  
7 PURSUANT TO SECTION 36-2912.02.

8 B. FINANCIAL REQUIREMENTS IMPOSED PURSUANT TO TITLE 36, CHAPTER 29,  
9 ARTICLE 1 ARE SEPARATE FROM THE FINANCIAL REQUIREMENTS IMPOSED PURSUANT TO  
10 THIS TITLE.

11 Sec. 2. Section 36-2901.03, Arizona Revised Statutes, is amended to  
12 read:

13 36-2901.03. Federal poverty program; eligibility

14 A. The administration shall adopt rules for a streamlined eligibility  
15 determination process for any person who applies to be an eligible person as  
16 defined in section 36-2901, paragraph 6, subdivision (a), item (iv). The  
17 administration shall adopt these rules in accordance with state and federal  
18 requirements and the section 1115 waiver.

19 B. The administration must base eligibility on an adjusted gross  
20 income that does not exceed one hundred per cent of the federal poverty  
21 guidelines.

22 C. For persons who the administration determines are eligible pursuant  
23 to this section, the date of eligibility is the first day of the month of  
24 application.

25 D. The administration shall determine an eligible person's continued  
26 eligibility ~~every six months~~ ON AN ANNUAL BASIS.

27 Sec. 3. Repeal

28 Section 36-2906.01, Arizona Revised Statutes, as amended by Laws 2001,  
29 chapter 58, section 19, is repealed.

30 Sec. 4. Section 36-2906.01, Arizona Revised Statutes, as amended by  
31 Laws 2001, chapter 344, section 48, is amended to read:

32 36-2906.01. Qualified commercial carriers; administration;  
33 contracts

34 A. Entities, including insurers as defined in section 20-104,  
35 hospital, medical, dental and optometric service corporations defined in  
36 title 20, chapter 4, article 3, ~~benefit insurers as defined in section 20-922~~  
37 and health care services organizations as defined in section 20-1051, are  
38 prohibited from contracting with the administration as a system ~~health plan~~  
39 **CONTRACTOR** unless the entity establishes an affiliated corporation whose only  
40 authorized business is to provide services or coverage pursuant to a contract  
41 with the administration to persons defined as eligible in section 36-2901,  
42 paragraph 6, **SUBDIVISIONS (a), (f) AND (g)**.

43 B. If there is an insufficient number of, or an inadequate member  
44 capacity in, contracts awarded to ~~prepaid capitated providers~~ **CONTRACTORS**,  
45 the director may request that the director of the department of insurance

1 grant a temporary exemption from the requirements of subsection A of this  
2 section for an entity regulated by the department of insurance, and otherwise  
3 qualified to be a system health plan, in order for that entity to enter into  
4 an arrangement with the administration to provide services to persons defined  
5 as eligible in section 36-2901, paragraph 6, **SUBDIVISIONS (a), (f) AND (g)**.  
6 On a written request from the administration, the director of the department  
7 of insurance may grant a one-time exemption to an entity, for a period not to  
8 exceed one year. During the temporary exemption, the entity must comply with  
9 all applicable provisions of both this article and the applicable chapter or  
10 article of title 20 under which the entity is licensed to operate.

11 C. With respect to entities that have been granted an exemption  
12 pursuant to subsection B of this section, the provisions of section 36-2903,  
13 subsection M, ~~related~~ **RELATING** to the direct operation of a provider, shall  
14 not apply. If the director determines that the operations of the entity  
15 would otherwise meet the circumstances specified in contract under which the  
16 administration could operate the entity directly or that the public health,  
17 safety or welfare require emergency action relative to the entity, the  
18 director shall notify the director of the department of insurance and may  
19 request that the department of insurance take appropriate actions.

20 Sec. 5. Section 36-2912, Arizona Revised Statutes, is amended to read:

21 **36-2912. Healthcare group coverage; program requirements for**  
22 **small businesses and public employers; related**  
23 **requirements; definitions**

24 A. The administration shall administer a healthcare group program to  
25 allow willing contractors to deliver health care services to persons defined  
26 as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c),  
27 (d) and (e). **IN THE ABSENCE OF A WILLING CONTRACTOR, THE ADMINISTRATION MAY**  
28 **CONTRACT DIRECTLY WITH ANY HEALTH CARE PROVIDER OR ENTITY. THE**  
29 **ADMINISTRATION MAY ENTER INTO A CONTRACT WITH ANOTHER ENTITY TO PROVIDE**  
30 **ADMINISTRATIVE FUNCTIONS FOR THE HEALTHCARE GROUP PROGRAM.**

31 B. Employers with one eligible employee or up to an average of fifty  
32 eligible employees under section 36-2901, paragraph 6, subdivision (d):

33 1. May contract with the administration to be the exclusive health  
34 benefit plan if the employer has five or fewer eligible employees and enrolls  
35 one hundred per cent of these employees into the health benefit plan.

36 2. May contract with the administration for coverage available  
37 pursuant to this section if the employer has six or more eligible employees  
38 and enrolls eighty per cent of these employees into the healthcare group  
39 program.

40 3. Shall have a minimum of one and a maximum of fifty eligible  
41 employees at the effective date of their first contract with the  
42 administration.

43 **C. THE ADMINISTRATION SHALL NOT ENROLL AN EMPLOYER GROUP IN HEALTHCARE**  
44 **GROUP SOONER THAN ONE HUNDRED EIGHTY DAYS AFTER THE DATE THAT THE EMPLOYER'S**  
45 **HEALTH INSURANCE COVERAGE UNDER AN ACCOUNTABLE HEALTH PLAN IS DISCONTINUED.**

1 ENROLLMENT IN HEALTHCARE GROUP IS EFFECTIVE ON THE FIRST DAY OF THE MONTH  
2 AFTER THE ONE HUNDRED EIGHTY DAY PERIOD. THIS SUBSECTION DOES NOT APPLY TO  
3 AN EMPLOYER GROUP IF THE EMPLOYER'S ACCOUNTABLE HEALTH PLAN DISCONTINUES  
4 OFFERING THE HEALTH PLAN OF WHICH THE EMPLOYER IS A MEMBER.

5 ~~C.~~ D. Employees with proof of other existing health care coverage who  
6 elect not to participate in the healthcare group program shall not be  
7 considered when determining the percentage OF ENROLLMENT REQUIREMENTS UNDER  
8 SUBSECTION B OF THIS SECTION if ~~the other health care coverage~~ either:

9 1. ~~Is other~~ Group health coverage IS PROVIDED through a spouse, parent  
10 or legal guardian, OR INSURED THROUGH INDIVIDUAL INSURANCE OR ANOTHER  
11 EMPLOYER.

12 2. ~~Is coverage available from~~ MEDICAL ASSISTANCE IS PROVIDED BY a  
13 government subsidized health care program.

14 3. MEDICAL ASSISTANCE IS PROVIDED PURSUANT TO SECTION 36-2982,  
15 SUBSECTION I.

16 ~~D.~~ E. An employer shall not offer coverage made available pursuant to  
17 this section to persons defined as eligible pursuant to section 36-2901,  
18 paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally  
19 designated plan.

20 ~~E.~~ F. An employee or dependent defined as eligible pursuant to  
21 section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may  
22 participate in ~~the system~~ HEALTHCARE GROUP on a voluntary basis only.

23 ~~F.~~ G. Notwithstanding subsection B, paragraph 2 of this section, the  
24 administration shall adopt rules to allow a business that offers ~~system~~  
25 HEALTHCARE GROUP coverage pursuant to this section to continue coverage if it  
26 expands its employment to include more than fifty employees.

27 ~~G.~~ H. The administration shall provide eligible employees with  
28 disclosure information about the health benefit plan.

29 ~~H.~~ I. The director shall:

30 1. Require that any contractor that provides covered services to  
31 persons defined as eligible pursuant to section 36-2901, paragraph 6,  
32 subdivision (a) provide separate audited reports on the assets, liabilities  
33 and financial status of any corporate activity involving providing coverage  
34 pursuant to this section to persons defined as eligible pursuant to section  
35 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

36 ~~2. Ensure that any health plan not contracted to provide system~~  
37 ~~covered services to persons defined as eligible pursuant to section 36-2901,~~  
38 ~~paragraph 6, subdivision (a) has complied with any applicable provisions of~~  
39 ~~section 36-2906.01. The director may make requests of the director of the~~  
40 ~~department of insurance on behalf of the administration pursuant to section~~  
41 ~~36-2906.01.~~

42 ~~3. Not distribute any appropriated funds, unless specifically~~  
43 ~~authorized by the legislature, to the administration or the administration's~~  
44 ~~contracted plans for the purposes of this section.~~

1           2. BEGINNING ON JULY 1, 2005, REQUIRE THAT A CONTRACTOR, THE  
2 ADMINISTRATION OR AN ACCOUNTABLE HEALTH PLAN NEGOTIATE REIMBURSEMENT RATES  
3 AND NOT USE THE ADMINISTRATION'S REIMBURSEMENT RATES ESTABLISHED PURSUANT TO  
4 SECTION 36-2903.01, SUBSECTION H, AS A DEFAULT REIMBURSEMENT RATE IF A  
5 CONTRACT DOES NOT EXIST BETWEEN A CONTRACTOR AND A PROVIDER.

6           3. USE MONIES FROM THE HEALTHCARE GROUP FUND ESTABLISHED BY SECTION  
7 36-2912.01 FOR THE ADMINISTRATION'S COSTS OF OPERATING THE HEALTHCARE GROUP  
8 PROGRAM.

9           4. Ensure that the contractors are required to meet contract terms as  
10 are necessary in the judgment of the director to ensure adequate performance  
11 by the contractor. Contract provisions shall include, at a minimum, the  
12 maintenance of deposits, performance bonds, financial reserves or other  
13 financial security. The director may waive requirements for the posting of  
14 bonds or security for contractors that have posted other security, equal to  
15 or greater than that required for the healthcare group program, with the  
16 administration or the department of insurance for the performance of health  
17 service contracts if funds would be available to the administration from the  
18 other security on the contractor's default. In waiving, or approving waivers  
19 of, any requirements established pursuant to this section, the director shall  
20 ensure that the administration has taken into account all the obligations to  
21 which a contractor's security is associated. The director may also adopt  
22 rules that provide for the withholding or forfeiture of payments to be made  
23 to a contractor for the failure of the contractor to comply with provisions  
24 of its contract or with provisions of adopted rules.

25           5. Adopt rules.

26           6. Provide reinsurance to the contractors for clean claims based on  
27 thresholds established by the administration. For the purposes of this  
28 paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

29           ~~I.~~ J. With respect to services provided by contractors to persons  
30 defined as eligible pursuant to section 36-2901, paragraph 6, subdivision  
31 (b), (c), (d) or (e), a contractor is the payor of last resort and has the  
32 same lien or subrogation rights as those held by health care services  
33 organizations licensed pursuant to title 20, chapter 4, article 9.

34           ~~J.~~ K. The administration shall offer a health benefit plan on a  
35 guaranteed issuance basis to small employers as required by this  
36 section. All small employers qualify for this guaranteed offer of coverage.  
37 The administration shall provide a health benefit plan to each small employer  
38 without regard to health status-related factors if the small employer agrees  
39 to make the premium payments and to satisfy any other reasonable provisions  
40 of the plan ~~that are not inconsistent with this chapter~~ AND CONTRACT. The  
41 administration shall offer to all small employers the available health  
42 benefit plan and shall accept any small employer that applies and meets the  
43 eligibility requirements. In addition to the requirements prescribed in this  
44 section, for any offering of any health benefit plan to a small employer, as  
45 part of the administration's solicitation and sales materials, the

1 administration shall make a reasonable disclosure to the employer of the  
2 availability of the information described in this subsection and, on request  
3 of the employer, shall provide that information to the employer. The  
4 administration shall provide information concerning the following:

5 1. Provisions of coverage relating to the following, if applicable:

6 (a) The administration's right to establish premiums and to change  
7 premium rates and the factors that may affect changes in premium rates.

8 (b) Renewability of coverage.

9 (c) Any preexisting condition exclusion.

10 (d) The geographic areas served by the contractor.

11 2. The benefits and premiums available under all health benefit plans  
12 for which the employer is qualified.

13 ~~K~~ L. The administration shall describe the information required by  
14 subsection ~~J~~ K of this section in language that is understandable by the  
15 average small employer and with a level of detail that is sufficient to  
16 reasonably inform a small employer of the employer's rights and obligations  
17 under the health benefit plan. This requirement is satisfied if the  
18 administration provides the following information:

19 1. An outline of coverage that describes the benefits in summary form.

20 2. The rate or rating schedule that applies to the product,  
21 preexisting condition exclusion or affiliation period.

22 3. The minimum employer contribution and group participation rules  
23 that apply to any particular type of coverage.

24 4. In the case of a network plan, a map or listing of the areas  
25 served.

26 ~~L~~ M. A contractor is not required to disclose any information that  
27 is proprietary and protected trade secret information under applicable law.

28 ~~M~~ N. At least sixty days before the date of expiration of a health  
29 benefit plan, the administration shall provide a written notice to the  
30 employer of the terms for renewal of the plan.

31 ~~N~~ O. The administration may increase or decrease premiums based on  
32 actuarial reviews of the projected and actual costs of providing health care  
33 benefits to eligible members. Before changing premiums, the administration  
34 must give sixty ~~days~~ DAYS' written notice to the employer. The  
35 administration may cap the amount of the change.

36 ~~O~~ P. The administration may consider age, sex, income and community  
37 rating when it establishes premiums for the healthcare group program.

38 ~~P~~ Q. Except as provided in subsection ~~Q~~ R of this section, a health  
39 benefit plan may not deny, limit or condition the coverage or benefits based  
40 on a person's health status-related factors or a lack of evidence of  
41 insurability.

42 ~~Q~~ R. A health benefit plan shall not exclude coverage for  
43 preexisting conditions, except that:

44 1. A health benefit plan may exclude coverage for preexisting  
45 conditions for a period of not more than twelve months or, in the case of a

1 late enrollee, eighteen months. The exclusion of coverage does not apply to  
2 services that are furnished to newborns who were otherwise covered from the  
3 time of their birth or to persons who satisfy the portability requirements  
4 under this section.

5 2. The contractor shall reduce the period of any applicable  
6 preexisting condition exclusion by the aggregate of the periods of creditable  
7 coverage that apply to the individual.

8 ~~R.~~ S. The contractor shall calculate creditable coverage according to  
9 the following:

10 1. The contractor shall give an individual credit for each portion of  
11 each month the individual was covered by creditable coverage.

12 2. The contractor shall not count a period of creditable coverage for  
13 an individual enrolled in a health benefit plan if after the period of  
14 coverage and before the enrollment date there were sixty-three consecutive  
15 days during which the individual was not covered under any creditable  
16 coverage.

17 3. The contractor shall give credit in the calculation of creditable  
18 coverage for any period that an individual is in a waiting period for any  
19 health coverage.

20 ~~S.~~ T. The contractor shall not count a period of creditable coverage  
21 with respect to enrollment of an individual if, after the most recent period  
22 of creditable coverage and before the enrollment date, sixty-three  
23 consecutive days lapse during all of which the individual was not covered  
24 under any creditable coverage. The contractor shall not include in the  
25 determination of the period of continuous coverage described in this section  
26 any period that an individual is in a waiting period for health insurance  
27 coverage offered by a health care insurer or is in a waiting period for  
28 benefits under a health benefit plan offered by a contractor. In determining  
29 the extent to which an individual has satisfied any portion of any applicable  
30 preexisting condition period the contractor shall count a period of  
31 creditable coverage without regard to the specific benefits covered during  
32 that period. A contractor shall not impose any preexisting condition  
33 exclusion in the case of an individual who is covered under creditable  
34 coverage thirty-one days after the individual's date of birth. A contractor  
35 shall not impose any preexisting condition exclusion in the case of a child  
36 who is adopted or placed for adoption before age eighteen and who is covered  
37 under creditable coverage thirty-one days after the adoption or placement for  
38 adoption.

39 ~~T.~~ U. The written certification provided by the administration must  
40 include:

41 1. The period of creditable coverage of the individual under the  
42 contractor and any applicable coverage under a COBRA continuation provision.

43 2. Any applicable waiting period or affiliation period imposed on an  
44 individual for any coverage under the health plan.

1           ~~U~~ V. The administration shall issue and accept a written  
2 certification of the period of creditable coverage of the individual that  
3 contains at least the following information:

4           1. The date that the certificate is issued.

5           2. The name of the individual or dependent for whom the certificate  
6 applies and any other information that is necessary to allow the issuer  
7 providing the coverage specified in the certificate to identify the  
8 individual, including the individual's identification number under the policy  
9 and the name of the policyholder if the certificate is for or includes a  
10 dependent.

11           3. The name, address and telephone number of the issuer providing the  
12 certificate.

13           4. The telephone number to call for further information regarding the  
14 certificate.

15           5. One of the following:

16           (a) A statement that the individual has at least eighteen months of  
17 creditable coverage. For purposes of this subdivision, eighteen months means  
18 five hundred forty-six days.

19           (b) Both the date that the individual first sought coverage, as  
20 evidenced by a substantially complete application, and the date that  
21 creditable coverage began.

22           6. The date creditable coverage ended, unless the certificate  
23 indicates that creditable coverage is continuing from the date of the  
24 certificate.

25           ~~V~~ W. The administration shall provide any certification pursuant to  
26 this section within thirty days after the event that triggered the issuance  
27 of the certification. Periods of creditable coverage for an individual are  
28 established by presentation of the certifications in this section.

29           ~~W~~ X. The healthcare group program shall comply with all applicable  
30 federal requirements.

31           Y. HEALTHCARE GROUP MAY PAY A COMMISSION TO AN INSURANCE PRODUCER. TO  
32 RECEIVE A COMMISSION, THE PRODUCER MUST CERTIFY THAT TO THE BEST OF THE  
33 PRODUCER'S KNOWLEDGE THE EMPLOYER GROUP HAS NOT HAD INSURANCE IN THE ONE  
34 HUNDRED EIGHTY DAYS BEFORE APPLYING TO HEALTHCARE GROUP. FOR THE PURPOSES OF  
35 THIS SUBSECTION, "COMMISSION" MEANS A ONE TIME PAYMENT ON THE INITIAL  
36 ENROLLMENT OF AN EMPLOYER.

37           Z. ON OR BEFORE JUNE 15 AND NOVEMBER 15 OF EACH YEAR, THE DIRECTOR  
38 SHALL SUBMIT A REPORT TO THE JOINT LEGISLATIVE BUDGET COMMITTEE REGARDING THE  
39 NUMBER AND TYPE OF BUSINESSES PARTICIPATING IN HEALTHCARE GROUP AND THAT  
40 INCLUDES UPDATED INFORMATION ON HEALTHCARE GROUP MARKETING ACTIVITIES. THE  
41 DIRECTOR SHALL, WITHIN THIRTY DAYS OF IMPLEMENTATION, NOTIFY THE JOINT  
42 LEGISLATIVE BUDGET COMMITTEE OF ANY CHANGES IN HEALTHCARE GROUP BENEFITS OR  
43 COST SHARING ARRANGEMENTS.

- 1           ~~X~~ AA. For the purposes of this section:
- 2           1. "ACCOUNTABLE HEALTH PLAN" HAS THE SAME MEANING PRESCRIBED IN
- 3 SECTION 20-2301.
- 4           ~~1~~ 2. "COBRA continuation provision" means:
- 5           (a) Section 4980B, except subsection (f)(1) as it relates to pediatric
- 6 vaccines, of the internal revenue code of 1986.
- 7           (b) Title I, subtitle B, part 6, except section 609, of the employee
- 8 retirement income security act of 1974.
- 9           (c) Title XXII of the public health service act.
- 10           (d) Any similar provision of the law of this state or any other state.
- 11           ~~2~~ 3. "Creditable coverage" means coverage solely for an individual,
- 12 other than limited benefits coverage, under any of the following:
- 13           (a) An employee welfare benefit plan that provides medical care to
- 14 employees or the employees' dependents directly or through insurance,
- 15 reimbursement or otherwise pursuant to the employee retirement income
- 16 security act of 1974.
- 17           (b) A church plan as defined in the employee retirement income
- 18 security act of 1974.
- 19           (c) A health ~~benefit~~ BENEFITS plan, as defined in section 20-2301,
- 20 issued by a health plan.
- 21           (d) Part A or part B of title XVIII of the social security act.
- 22           (e) Title XIX of the social security act, other than coverage
- 23 consisting solely of benefits under section 1928.
- 24           (f) Title 10, chapter 55 of the United States Code.
- 25           (g) A medical care program of the Indian health service or of a tribal
- 26 organization.
- 27           (h) A health benefits risk pool operated by any state of the United
- 28 States.
- 29           (i) A health plan offered pursuant to title 5, chapter 89 of the
- 30 United States Code.
- 31           (j) A public health plan as defined by federal law.
- 32           (k) A health benefit plan pursuant to section 5(e) of the peace corps
- 33 act (22 United States Code section 2504(e)).
- 34           (l) A policy or contract, including short-term limited duration
- 35 insurance, issued on an individual basis by an insurer, a health care
- 36 services organization, a hospital service corporation, a medical service
- 37 corporation or a hospital, medical, dental and optometric service corporation
- 38 or made available to persons defined as eligible under section 36-2901,
- 39 paragraph 6, subdivisions (b), (c), (d) and (e).
- 40           (m) A policy or contract issued by a health care insurer or the
- 41 administration to a member of a bona fide association.
- 42           ~~3~~ 4. "Eligible employee" means a person who IS ONE OF THE FOLLOWING:
- 43           (a) ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISIONS
- 44 (b), (c), (d) AND (e).

1 (b) A PERSON WHO works for an employer for a minimum of twenty hours  
2 per week or who is self-employed for at least twenty hours per week.

3 (c) AN EMPLOYEE WHO ELECTS COVERAGE PURSUANT TO SECTION 36-2982,  
4 SUBSECTION I. THE RESTRICTION PROHIBITING EMPLOYEES EMPLOYED BY PUBLIC  
5 AGENCIES PRESCRIBED IN SECTION 36-2982, SUBSECTION I DOES NOT APPLY TO THIS  
6 SUBDIVISION.

7 (d) A PERSON WHO MEETS ALL OF THE ELIGIBILITY REQUIREMENTS, WHO IS  
8 ELIGIBLE FOR A FEDERAL HEALTH COVERAGE TAX CREDIT PURSUANT TO SECTION 35 OF  
9 THE INTERNAL REVENUE CODE OF 1986 AND WHO APPLIES FOR HEALTH CARE COVERAGE  
10 THROUGH THE HEALTHCARE GROUP PROGRAM. THE REQUIREMENT THAT A PERSON BE  
11 EMPLOYED WITH A SMALL BUSINESS THAT ELECTS HEALTHCARE GROUP COVERAGE DOES NOT  
12 APPLY TO THIS ELIGIBILITY GROUP.

13 ~~4.~~ 5. "Genetic information" means information about genes, gene  
14 products and inherited characteristics that may derive from the individual or  
15 a family member, including information regarding carrier status and  
16 information derived from laboratory tests that identify mutations in specific  
17 genes or chromosomes, physical medical examinations, family histories and  
18 direct analysis of genes or chromosomes.

19 ~~5.~~ 6. "Health benefit plan" means coverage offered by the  
20 administration for the healthcare group program pursuant to this section.

21 ~~6.~~ 7. "Health status-related factor" means any factor in relation to  
22 the health of the individual or a dependent of the individual enrolled or to  
23 be enrolled in a health plan including:

- 24 (a) Health status.
- 25 (b) Medical condition, including physical and mental illness.
- 26 (c) Claims experience.
- 27 (d) Receipt of health care.
- 28 (e) Medical history.
- 29 (f) Genetic information.
- 30 (g) Evidence of insurability, including conditions arising out of acts  
31 of domestic violence as defined in section 20-448.
- 32 (h) The existence of a physical or mental disability.

33 8. "HOSPITAL" MEANS A HEALTH CARE INSTITUTION LICENSED AS A HOSPITAL  
34 PURSUANT TO CHAPTER 4, ARTICLE 2 OF THIS TITLE.

35 ~~7.~~ 9. "Late enrollee" means an employee or dependent who requests  
36 enrollment in a health benefit plan after the initial enrollment period that  
37 is provided under the terms of the health benefit plan if the initial  
38 enrollment period is at least thirty-one days. Coverage for a late enrollee  
39 begins on the date the person becomes a dependent if a request for enrollment  
40 is received within thirty-one days after the person becomes a dependent. An  
41 employee or dependent shall not be considered a late enrollee if:

- 42 (a) The person:
  - 43 (i) At the time of the initial enrollment period was covered under a  
44 public or private health insurance policy or any other health benefit plan.

1 (ii) Lost coverage under a public or private health insurance policy  
2 or any other health benefit plan due to the employee's termination of  
3 employment or eligibility, the reduction in the number of hours of  
4 employment, the termination of the other plan's coverage, the death of the  
5 spouse, legal separation or divorce or the termination of employer  
6 contributions toward the coverage.

7 (iii) Requests enrollment within thirty-one days after the termination  
8 of creditable coverage that is provided under a COBRA continuation provision.

9 (iv) Requests enrollment within thirty-one days after the date of  
10 marriage.

11 (b) The person is employed by an employer that offers multiple health  
12 benefit plans and the person elects a different plan during an open  
13 enrollment period.

14 (c) The person becomes a dependent of an eligible person through  
15 marriage, birth, adoption or placement for adoption and requests enrollment  
16 no later than thirty-one days after becoming a dependent.

17 ~~8-~~ 10. "Preexisting condition" means a condition, regardless of the  
18 cause of the condition, for which medical advice, diagnosis, care or  
19 treatment was recommended or received within not more than six months before  
20 the date of the enrollment of the individual under a health benefit plan  
21 issued by a contractor. Preexisting condition does not include a genetic  
22 condition in the absence of a diagnosis of the condition related to the  
23 genetic information.

24 ~~9-~~ 11. "Preexisting condition limitation" or "preexisting condition  
25 exclusion" means a limitation or exclusion of benefits for a preexisting  
26 condition under a health benefit plan offered by a contractor.

27 ~~10-~~ 12. "Small employer" means an employer who employs at least one  
28 but not more than fifty eligible employees on a typical business day during  
29 any one calendar year.

30 ~~11-~~ 13. "Waiting period" means the period that must pass before a  
31 potential participant or eligible employee in a health benefit plan offered  
32 by a health plan is eligible to be covered for benefits as determined by the  
33 individual's employer.

34 Sec. 6. Title 36, chapter 29, article 1, Arizona Revised Statutes, is  
35 amended by adding sections 36-2912.01 and 36-2912.02, to read:

36 ~~36-2912.01.~~ Healthcare group fund; nonlapsing

37 A. THE HEALTHCARE GROUP FUND IS ESTABLISHED CONSISTING OF:

38 1. PREMIUMS PAID BY SMALL EMPLOYERS AND ELIGIBLE EMPLOYEES, INCLUDING  
39 EMPLOYEE CONTRIBUTIONS, FOR THE COST OF PROVIDING HOSPITALIZATION AND MEDICAL  
40 CARE UNDER THE SYSTEM.

41 2. GIFTS, GRANTS AND DONATIONS.

42 3. LEGISLATIVE APPROPRIATIONS.

43 B. THE ADMINISTRATION SHALL ADMINISTER THE FUND.

44 C. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND ARE EXEMPT  
45 FROM THE PROVISIONS OF SECTION 35-190 RELATING TO THE LAPSING OF

1 APPROPRIATIONS. ADMINISTRATIVE COSTS TO OPERATE THE PROGRAM ARE SUBJECT TO  
2 LEGISLATIVE APPROPRIATION.

3 D. ON NOTICE FROM THE ADMINISTRATION, THE STATE TREASURER SHALL INVEST  
4 AND DIVEST MONIES IN THE FUND AS PROVIDED BY SECTION 35-313, AND MONIES  
5 EARNED FROM INVESTMENT SHALL BE CREDITED TO THE FUND.

6 E. THE ADMINISTRATION SHALL USE FUND MONIES TO PAY THE ADMINISTRATIVE  
7 COSTS AND THE COST OF PROVIDING HOSPITALIZATION AND MEDICAL CARE FOR SMALL  
8 EMPLOYERS AND ELIGIBLE EMPLOYEES AS DEFINED IN SECTION 36-2912.

9 F. SUBJECT TO LEGISLATIVE APPROPRIATION, THE ADMINISTRATION MAY USE  
10 FUND MONIES FROM PREMIUMS TO PAY THE ADMINISTRATIVE COSTS FOR THE  
11 ADMINISTRATION TO OPERATE THE HEALTHCARE GROUP PROGRAM. ADMINISTRATIVE COSTS  
12 DO NOT INCLUDE COMMISSIONS OR FEES PAID BY THE HEALTHCARE PROGRAM TO  
13 INSURANCE PRODUCERS.

14 36-2912.02. Qualified commercial carriers; healthcare group  
15 contracts; definition

16 A. NOTWITHSTANDING ANY LAW TO THE CONTRARY, THE DIRECTOR MAY ISSUE A  
17 REQUEST FOR PROPOSAL AND CONTRACT WITH AN ACCOUNTABLE HEALTH PLAN TO PROVIDE  
18 SERVICES TO PERSONS WHO ARE ELIGIBLE PURSUANT TO SECTION 36-2912. THE  
19 CONTRACT MUST INCLUDE THE SAME REQUIREMENTS IN SECTION 36-2912 THAT MUST BE  
20 MET BY HEALTHCARE GROUP CONTRACTORS AND MUST SPECIFY THE MINIMUM REQUIREMENTS  
21 FOR A PERFORMANCE BOND, EQUITY REQUIREMENTS, OTHER FINANCIAL RESERVES DEEMED  
22 NECESSARY BY THE ADMINISTRATION AND ANY OTHER FINANCIAL, PROGRAMMATIC AND  
23 OPERATIONAL REQUIREMENTS THAT MUST BE MET BY THE ACCOUNTABLE HEALTH  
24 PLAN. THE ADMINISTRATION SHALL MONITOR COMPLIANCE AND ENFORCE THE  
25 REQUIREMENTS PRESCRIBED BY THE CONTRACT AND THIS SECTION.

26 B. AN ACCOUNTABLE HEALTH PLAN THAT CONTRACTS WITH THE ADMINISTRATION  
27 TO PROVIDE HEALTHCARE GROUP SERVICES MUST COMPLY WITH THE ADMINISTRATION'S  
28 CONTRACT REQUIREMENTS AND THE REQUIREMENTS OF THIS ARTICLE THAT ARE  
29 APPLICABLE TO HEALTHCARE GROUP CONTRACTORS.

30 C. TO THE EXTENT THAT SERVICES ARE PROVIDED PURSUANT TO THIS ARTICLE,  
31 THE REQUIREMENTS OF TITLE 20 DO NOT APPLY TO AN ACCOUNTABLE HEALTH PLAN.

32 D. AN ACCOUNTABLE HEALTH PLAN IS NOT REQUIRED TO BE A CONTRACTOR OR  
33 ESTABLISH AN AFFILIATED CORPORATION AS PRESCRIBED IN SECTION 36-2906.01.

34 E. FOR THE PURPOSES OF THIS SECTION, "ACCOUNTABLE HEALTH PLAN" HAS THE  
35 SAME MEANING PRESCRIBED IN SECTION 20-2301.

36 Sec. 7. Section 36-2913, Arizona Revised Statutes, is amended to read:

37 36-2913. Systems funds; funding

38 A. The Arizona health care cost containment system fund, long-term  
39 care system fund and the third party liability fund are established. The  
40 funds shall be used to pay administrative and program costs associated with  
41 the operation of the system established pursuant to this article and the  
42 long-term care system established pursuant to article 2 of this chapter.

43 B. Separate accounts, including but not limited to a reserve fund, may  
44 be established within the funds. Different accounts within the funds shall  
45 be established in order to separately account for expense and income activity

1 associated with the system established pursuant to this article and article 2  
2 of this chapter.

3 C. The Arizona health care cost containment system fund and long-term  
4 care system fund shall be comprised of:

5 1. Monies paid by each of the counties of this state of the amounts  
6 determined or withheld by the state treasurer pursuant to section 11-292.

7 2. Monies paid by each county resolving to participate in the system  
8 equal to the actual cost, as limited by the board of supervisors, together  
9 with employee contributions of providing hospitalization and medical care  
10 under the system to full-time officers and employees of the county and its  
11 departments and agencies.

12 3. Monies paid by this state equal to the actual cost, as limited by  
13 section 38-651, together with employee contributions of providing  
14 hospitalization and medical care under the system to full-time officers and  
15 employees of this state, of its departments and agencies and of cities, towns  
16 and school districts of this state.

17 4. Monies drawn against appropriations made by this state for the  
18 costs of operating the Arizona health care cost containment system or the  
19 long-term care system. Monies shall be drawn against appropriations and  
20 transferred from the fund from which they were appropriated on an as needed  
21 basis only.

22 5. Gifts, donations and grants from any source.

23 6. Federal monies made available to this state for the operation of  
24 the Arizona health care cost containment system or the long-term care system.

25 7. Interest paid on monies deposited in the fund.

26 ~~8. Monies paid by the owners of eligible businesses in this state,  
27 including employee contributions, for the actual cost of providing  
28 hospitalization and medical care under the system to their full-time  
29 employees together with interest paid on monies deposited in the fund.  
30 Administrative costs of the system to operate the eligible businesses program  
31 are subject to legislative appropriation.~~

32 ~~9.~~ 8. Reimbursements for data collection.

33 D. The third party liability fund is comprised of monies paid by third  
34 party payors and lien and estate recoveries.

35 E. All monies in the funds other than monies appropriated by the state  
36 shall not lapse.

37 F. All monies drawn against appropriations made by this state  
38 remaining in the funds at the end of the fiscal year shall revert to the fund  
39 from which they were appropriated and drawn, and the appropriation shall  
40 lapse in accordance with section 35-190. Notwithstanding the provisions of  
41 section 35-191, subsection B, the period for administrative adjustments shall  
42 extend for only six months for appropriations made for system covered  
43 services.

44 G. Notwithstanding sections 35-190 and 35-191, all approved claims for  
45 system covered services presented after the close of the fiscal year in which

1 they were incurred shall be paid either in accordance with subsection F of  
2 this section or in the current fiscal year with the monies available in the  
3 funds established by this section.

4 H. Claims for system covered services that are determined valid by the  
5 director pursuant to section 36-2904, subsection G and the department's  
6 grievance and appeal procedure shall be paid from the funds established by  
7 this section.

8 I. For purposes of this section, system covered services exclude  
9 administrative charges for operating expenses.

10 J. All payments for claims from the funds established by this section  
11 shall be accounted for by the administration by the fiscal year in which the  
12 claims were incurred, regardless of the fiscal year in which the payments  
13 were made.

14 K. Notwithstanding any other law, county owned or contracted providers  
15 and special health care district owned or contracted providers are subject to  
16 all claims processing and payment requirements or limitations of this chapter  
17 that are applicable to noncounty providers.

18 Sec. 8. Healthcare group; bare period; exception

19 Notwithstanding section 36-2912, subsection C, Arizona Revised  
20 Statutes, an employer who has signed and submitted to healthcare group a  
21 group service agreement to enroll employees with healthcare group before the  
22 effective date of this act does not have to meet the one hundred eighty day  
23 waiting period required by section 36-2912, subsection B, Arizona Revised  
24 Statutes, as amended by this act. If an employer requests healthcare group  
25 to cancel the group service agreement submitted before the effective date of  
26 this act or the employer does not provide all necessary documentation  
27 requested by healthcare group to complete the application process within  
28 ninety days from the original date of submittal to healthcare group, the  
29 provisions of section 36-2912, subsection B, Arizona Revised Statutes, as  
30 amended by this act, apply.

31 Sec. 9. Healthcare group; administrative expenses;  
32 appropriation

33 A. Subject to the availability of monies, \$3,207,400 is appropriated  
34 from the healthcare group fund established by section 36-2912.01, Arizona  
35 Revised Statutes, as added by this act in fiscal year 2004-2005 to the  
36 administration to pay the administrative costs to operate the healthcare  
37 group program.

38 B. The appropriation made in subsection A of this section is exempt  
39 from the provisions of section 35-190, Arizona Revised Statutes, relating to  
40 lapsing of appropriations.